Sex and youth: contextual factors affecting risk for HIV/AIDS

A comparative analysis of multi-site studies in developing countries

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UNAIDS BEST PRACTICE COLLECTION

Young people and risk-taking in sexual relations

Community responses to AIDS

Use of the female condom: genders relations and sexual negotiation

Young people and risk-taking in sexual relations

This set of studies presents a comparative analysis of data collected in interviews and discussions with nearly 3000 young people in 7 countries in Africa, Asia and the Americas. Strikingly similar themes and issues emerge, including concepts of youth, the challenge to traditional cultures, modernization and urbanization – revealing a complex and heterogeneous situation for young people and no one HIV/STD prevention strategy. Future prevention efforts must take into account the impact of dominant sexuality frameworks, the onset of sexual activity, the importance of the body for young people, mass media, risk assessment and safer sex.

Community responses to AIDS

A comparative analysis of the resulting data from 5 countries identified local beliefs about HIV/AIDS, the community and household responses and the inter-relations between the two. Key factors influencing the responses include the existing economic situation, prevailing relations between men and women in the communities and households, local beliefs in health and health care and local levels of stigmatization. Recommendations are made for policy and programme development.

Use of the female condom: genders relations and sexual negotiation

This third set of studies first collected data in 4 countries on gender relations, sexual communication and negotiation followed by an intervention to strengthen women's capacity in these latter areas. The comparative analysis clearly identified economic dependence on men and gender stereotypes as the two major factors constraining women in their sexual behaviour. The report finishes with specific recommendations.

This bare summary of these 3 pioneering sets of studies investigations into the determinants of HIV-related vulnerability cannot convey the extraordinary wealth of data and the richness of experiences and feelings reported by the participants with striking frankness. The volume will be read and re-read by national authorities, programme designers and managers, researchers and intervention specialists. In addition it will be of great interest and value to all those who are interested in the issues surrounding young people and HIV/AIDS, sexual behaviour, communication and negotiation, the improvement and strengthening of responses for the benefit of people living with HIV/AIDS, their carers and their communities, gender roles and the options for women who want to protect themselves against HIV and other STDs as well as pregnancy.

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Part 3

Use of the female condom: gender relations and sexual negotiation

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CHAPTER 1

INTRODUCTION

Several studies have demonstrated the efficacy of the female condom as a method of birth control and as a means of protection against STDs (e.g. Sai, 1993; Soper, Soupe, Shangold et al., 1993; Fontanet et al., 1998). Despite this encouraging research, the value of the female condom for HIV/AIDS prevention remains unclear, not least because unequal power relationships between men and women impact significantly on the ability of women to control the use of any prevention technology (du Guerny & Sjorberg, 1993). One possible means of reducing HIV transmission is to increase women's control over the means of prevention, but this demands good communication as well as access to resources for protection (Mane, Gupta & Weiss, 1994). While a number of studies have focused on the acceptability of the female condom, little research has been conducted into the ways in which its introduction might affect sexual communication and negotiation between men and women (FHI/AIDSCAP, 1997). The primary question underpinning these studies, therefore, was to what extent women's capacity to negotiate safer sex with their partners could be enhanced by the introduction of the female condom.

Simply making the female condom available is unlikely to shift the balance of power between men and women in the absence of other supportive interventions. A two-phase study was therefore designed. Assessment data were first collected over a 2 — 3-month period on prevailing patterns of gender relations, sexual communication and negotiation. Subsequently, an intervention took place to strengthen women's capacity for sexual communication and negotiation and to provide them with access to the female condom and knowledge and skills relevant to its use. Participants' experiences introducing the female condom into sexual negotiations were monitored. In each of four countries — Costa Rica, Indonesia, Mexico and Senegal — two groups of women participated in the research. One of these groups consisted of women engaged in sex work, the other consisted of women from a range of other backgrounds.

This comparative analysis of findings from these studies begins with a selective review of the literature on gender relations, heterosexual communication and negotiation, and the role of the female condom in safer sex (Chapter 1). The research methods used in each of the four sites are then described (Chapter 2) before data are analysed to highlight similarities and differences in findings across the four sites (Chapter 3). The emphasis is on the analysis of prevailing gender roles and relations, patterns of sexual communication, perceptions of risk, ways of 'negotiating' safer sex, the reactions of study participants and their partners to the female condom, and its impact on gender relations. A final chapter discusses the studies' implications for future policy and practice in HIV prevention.

The studies described were exploratory qualitative investigations and therefore exhibit the strengths

and limitations of this kind of enquiry. They provide insight into the nature of prevailing norms, relationships and processes of sexual communication and negotiation, but do not seek to measure or quantify these phenomena. No tests of statistical significance were performed on the data — such would have been inappropriate given sample sizes, the manner in which respondents were chosen, and the commitments of qualitative enquiry. This multi-site study *Use of the female condom: gender relations and sexual negotiation* seeks therefore to illuminate key issues and concerns which might be further examined, in research of perhaps a different kind.

CHAPTER 2

BACKGROUND

In most countries women are at particular risk of HIV infection. Recent estimates suggest that nearly half of those infected with HIV worldwide are women, and of the estimated 2.3 million people who died from HIV-related diseases in 1997 about a half were female (UNAIDS, 1997). Women constitute more than 50% of all adults with HIV infection in sub-Saharan Africa, more than 40% in the Caribbean, around 20% in central and south America, and about 30% in south and south-east Asia (UNAIDS & WHO, 1996). There is evidence to suggest that women have increased physiological vulnerability to HIV infection, it having been estimated that the risk of transmission from man to woman per exposure can be up to 2.5 times higher than that from woman to man (European Study Group on Heterosexual Transmission of HIV, 1992). Stereotypical gender roles and unequal power relationships between men and women, as well as increased economic and social vulnerability, mean that women are less likely to control how, when and where sex takes place (Mane, Gupta & Weiss, 1994; Heise & Elias, 1995; International Center for Research on Women, 1996).

Context

Developing countries have been among those most affected by HIV and AIDS (WHO, 1994a). Although, HIV prevalence varies considerably between countries, parts of Africa, south and central America and Asia have high and often rapidly increasing rates of infection (UNAIDS, 1997). While HIV can in theory affect anyone, globally there are marked inequalities of risk dependent on cultural and structural factors that are often beyond the control of individuals (Decosas, 1996). Sweat & Denison (1995) have recently described the ways in which social, economic and political forces such as poverty, migration, urbanization, war and civil disturbance facilitate HIV transmission. Women in developing countries may be at particularly high risk of acquiring HIV, and the special vulnerability of young women is now well documented. Estimates suggest that in Uganda, for example, HIV infection among young women aged 13-19 years can be up to 20 times higher than for men of the same age group (Panos Institute, 1996). In some cities in sub-Saharan Africa HIV prevalence among young pregnant women may be higher than 30% (Mann & Tarantola, 1996).

Several factors place women in developing countries at higher risk of HIV infection. Access to education is often more limited for girls than for boys; levels of literacy for females are usually lower than for males (Sivard, 1985); and women are more likely to be living in or vulnerable to poverty (Gupta & Weiss, 1993; Ankrah, 1996). Women are also more likely than men to experience sexual coercion or rape, and are more likely to sell sex in order to survive. In Malawi, two thirds of 168 young women recently surveyed reported having sexual intercourse in exchange for gifts or money, while at the University of Calabar in Nigeria nearly 15% of women studying said that they had received payment for sex in order to finance their education

(International Center for Research on Women, 1996).

Women may be drawn into sex work as a result of poverty or in order to pay off family debts. The Chiang Mai Hill Tribes Welfare and Development Center in Thailand, for example, has estimated that one in five girls coming into contact with the project provide sexual services for payment, and some have been sold or given into prostitution by family members (WHO, 1994b). In less precarious circumstances women often lack the resources and power to negotiate effectively with men over safer sex. Women participating in focus group discussions in Mumbai, India, for example have stated that, because of economic dependence and fear of physical violence, they must submit to their husband's sexual demands without opposition (George & Jaswal, 1994).

In many parts of the world, the tendency for women to have sexual partners older than themselves also increases vulnerability to HIV infection (Heise & Elias, 1995). Since such partners are often sexually experienced, they are more likely to be infected (Panos Institute, 1996). Research also shows that women's risk of acquiring HIV increases dramatically as age at first intercourse falls (Palloni & Lee, 1992), and exposure to HIV before physical maturity greatly increases the risk of infection (United Nations Development Project, 1992).

Social attitudes towards sexual activity vary dramatically. While sexual activity may be considered acceptable and even healthy for boys and young men, this is not the case for young women (see, for example, Bezmalinovic et al. 1994). The high value afforded to virginity in girls, in conjunction with a very different set of values for boys, can also enhance vulnerability to HIV infection. Moreover, young people interviewed in several recent studies have reported that anal sex is often used as a means to protect a girl's virginity (International Center for Research on Women, 1996).

Recent work in Mexico suggests that gender stereotypes affect young men's willingness to use condoms. They also promote the idea that whereas one partner may be appropriate for women, a 'real man' must have several different partners concurrently (Lemus, 1992). Stereotypes and expectations also place women at risk in cultures where being too knowledgeable about sex is seen as evidence of promiscuity. Recent studies in Thailand, for example, have shown that here as in other countries there are pressures on young women to be ignorant about sex for fear they will be seen as being too experienced (Cash & Anasuchatkal, 1993; Cash et al., 1997).

Women have often been identified as key players in the control of HIV — a focus that has been seen by some as reinforcing their traditional responsibility for the health of the household and as guardians of morality (Bland, 1985). A major criticism of some early HIV/AIDS prevention initiatives was that they failed to give enough attention to women's economic and social subordination, and the implications of this for their ability to negotiate where, when and how sex took place (FHI/AIDSCAP, 1997). This situation has changed, however, and there is now an increasing body of literature that suggests that gender empower-

ment is key to women's ability to protect themselves from HIV infection (Preston-Whyte, 1995). Additionally, there is growing acknowledgment that structural and political changes can help both women and men in developing countries protect themselves from HIV infection. Baldo (1995), for example, has stated that responsibility for the prevention of HIV infection is not solely a matter for the individual, but that social policies are needed to inhibit the growth of the epidemic. Policies, programmes and interventions to promote greater equality between men and women, and provide greater access to education for girls, are crucial to HIV prevention (d'Cruz-Grote, 1996).

Gender, power and sexuality

The term gender emphasizes the social shaping of femininity and masculinity, and challenges the idea that relations between women and men are ordained by nature. Social differences between men and women profoundly affect women's sexual relations with men, and gender and sexuality intersect with other social divisions such as those of race and social class (Holland, Ramazanoglu, Scott et al., 1992; Jackson & Scott, 1996). In most societies, gender inequalities cause women to have less access to and control over economic resources. This in turn leads to dependence on male partners and relatives for material survival. Women's socioeconomic position in turn affects their ability to enter into sexual relationships with men as equal partners and, even where there is a measure of equality, powerful norms about sexuality and sexual behaviour construct and constrain women's behaviour.

Gender inequalities are reflected in sexual relationships between women and men. Pressure and violence may be the outcomes when male demands for sex are not met (George, 1996, 1997; du Guerny & Sjorberg, 1993). Women not infrequently have to juggle the twin expectations of being sexually available without appearing to be sexually active. They may find themselves in circumstances where men expect them to provide sexual services either privately in the context of relationships and marriage, or commercially in the context of prostitution, on terms that are not of their making — circumstances which deny women the right to sexual autonomy and sexual pleasure. Women in a diverse range of countries have reported being unable to act upon what they know about HIV and AIDS for fear of implying through requests for condom use that a partner is not loved or not trusted. Such requests may disturb the intimacy that is central to many relationships and can result in violence, abandonment or rape (Ankrah & Attika, 1997).

In most countries women's experience of sex is constructed in relation to male sexual needs and wishes in a context of dependence and, in some cases, a discourse of romantic love. This is not, however, to suggest that women are simply the passive victims of male sexual demands. Both individually and collectively, women develop strategies for gaining sexual pleasure and for resisting the pressures imposed upon them by men, but they do so from an unequal starting point.

Sexual communication and 'negotiation'

The focus of many HIV prevention programmes to date has been the

promotion of mutual monogamy and condom use, both of which require good communication and negotiation between partners. Verbal communication may, however, be one of the most problematic aspects of heterosexual encounters (Holland, Ramazanoglu and Scott, 1990), and difficulty in sexual communication appears prevalent in countries as culturally disparate as the USA, Brazil and India (Goldstein, 1994; Bang & Bang, 1992). Participants in recent focus group discussions in Mumbai suggested that unequal power relations between men and women serve as a barrier to communication about sex between husband and wife (George & Jaswal, 1994; George, 1997), and an earlier survey of spousal communication in Asian countries found that almost a third of the women interviewed *never* talked to their husbands about sexual matters (McNamara, 1991). Research suggests that overt sexual communication between husbands and wives is also rare in many countries in sub-Saharan Africa (Caldwell, Caldwell & Quiggin, 1989).

Negotiating mutual monogamy most probably entails major changes in men's understandings of themselves as sexual beings, and while this emphasizes the need to prioritize work with men, bringing about such changes is probably not a realistic short-term expectation. Women participating in research in Thailand have commented that they would tend to think that a man who does not visit sex workers is not a 'real man' (Cash & Anasuchatkul, 1993), while women in Mumbai have expressed the view that a wife must accept her husband having partners outside marriage (George & Jaswal, 1994). Women participating in focus group discussions in Zambia have pointed out that while wives can (and possibly should) be monogamous, they cannot hope to control the number of partners had by a husband (Mushingeh, Chama & Mulikelela, 1991). While as a group women are more likely than men to be monogamous, individually they are also more likely to exchange sex for money or goods as part of a survival strategy (Heise & Elias, 1995). Promoting monogamy among women living in precarious economic circumstances may therefore be unrealistic unless alternative income-generating opportunities are also in place (Gupta, Mane & Weiss, 1996; Preston-Whyte, 1995; Benjamin, 1996).

Programmes promoting the use of condoms in HIV prevention also face difficulties caused by gender inequalities. Using condoms, for example, requires male agreement and women often have to negotiate with an unwilling partner (Heise & Elias, 1995; Elias & Coggins, 1996). Communication and negotiation about sex may be particularly difficult in cultural contexts where women are not meant to know anything about sex (Mane, Gupta & Weiss, 1994). Condoms can also carry negative associations. They may be seen as suitable for 'casual sex' but inappropriate in the context of a longer-term relationship (Cash & Anasuchatkul, 1993). Condoms may be associated with mistrust and some women fear that their partner may suspect them of unfaithfulness if they suggest condoms should be used. Others feel that suggesting the use of condoms is tantamount to accusing their husbands of infidelity (Heise & Elias, 1995; Ankrah & Attika, 1997). In order to persuade women and men to see condoms as a valuable means of protection, it is necessary to over-

come these negative associations. But it is also necessary to address inequalities of power as they influence sexual communication and negotiation for safer sex.

While the concept of sexual negotiation is problematic, since it implies a rationalism and autonomy that may not exist (Mane & Aggleton, 1996), there is evidence to suggest that in circumstances where women are able to influence the forms and contexts where sex occurs, HIV-related risks may be lowered. This may be true for some sex workers who are able to determine through the price charged the kind of sex that will take place. It may also be true for women who are in a position to withhold sex or some other service. Research has shown that some women in Nigeria, for example, are able to refuse sex without reprisal if their partner is known to have a STD, although it should be noted that the particular women surveyed enjoyed higher than usual degrees of economic independence (Orubuloye, Caldwell & Caldwell, 1992).

Central to the long-term success of HIV prevention are forms of protection over which women have more control and to which men offer less resistance (Heise & Elias, 1995; Elias & Coggins, 1996). Ideally, these might take the form of safe and undetectable microbicides over which a woman has control (Elias, 1996; Elias & Heise, 1996), but in the absence of these, barrier forms of protection such as that offered by the female condom may have an important role to play.

The female condom

The female condom was developed as a barrier method of contraception in the late 1980s by Phoenix Health Care (now Chartex International) of Chicago, Illinois. It is a cylindrical polyurethane bag about seven inches long with an integral outer ring at its wide end and a loose smaller inner ring at the closed end. This inner ring is used to guide the condom into the vagina and is then used to keep the condom in place against the cervix. The outer ring then holds the condom in place outside the vagina covering the woman's external genitalia.

Initial responses

Initial responses to the female condom were muted and there was sparse attendance at a poster presentation on its potential role in HIV prevention given by Leeper at the Vth International Conference on AIDS in Montreal in 1989. Anxieties were voiced about the likelihood of sex workers re-using the condom, a response that was in line with the view that women are 'risky' rather than at risk. For others working in HIV prevention, anticipation was tempered by concern. While some were positive about the prospect of a device that was under women's control, others were worried that it would place the task of preventing HIV transmission even more firmly in women's hands, absolving heterosexual men of responsibility for changing their behaviour and thereby reinforcing traditional gender relations (Panos Institute, 1990).

3 *The female condom received approval in the UK and some other European countries in 1991, and US Food and Drug Administration acceptance in 1992.*

Acceptability

Since it became available in the early 1990s,[3] the female condom has been fairly widely assessed for its acceptability and for its effectiveness as an STD prevention measure (George & Mane, 1996). In Europe and North America it has received a mixed response from health professionals, users and potential users (Lehto, 1991; Hoffman, 1991; Ford & Mathie, 1993; Gollub, Stein & El-Dadr, 1995; Perry, Sikkema, Wagstaffe et al., 1996). Studies in a variety of African (Ray et al., 1995; Ankrah, Kalckmann & Kabira, 1996; Timyan et al., 1996; MacIntyre et al., 1996; Musaba, Morrison & Sunkutu, 1996; Ankrah & Attika, 1997), Asian (Tansathit & Cheevakej, 1990; Chan, 1994; Jenkins et al., 1995) and South American (Gindin, n.d.; Ankrah & Attika, 1997) countries have shown that some groups of women relate positively to its use. A recent review of over 40 studies of female condom acceptability conducted worldwide concluded that the overall balance of view lies in its favour (UNDP/UNFPA/WHO/World Bank Special Programme of Research on Human Reproduction, 1997).

Effectiveness

While there is evidence that the female condom can be as effective as other barrier contraceptives (FHI/AIDSCAP, 1997), its effectiveness as a means of protection against STDs including HIV has as yet been less studied. What evidence there is suggests that it may be as likely as the male condom to protect against STDs such as trichomoniasis (Soper et al., 1993). A recent field study conducted with the support of the World Health Organization and UNAIDS in Thailand suggests that the female condom has potential to offer protection against STDs among women sex workers and their clients (Fontanet et al., 1998).

Cost

A major barrier to the use of the female condom is cost. This was found to be the main obstacle to use among women, including sex workers, in both urban and rural areas of Uganda who were in other respects overwhelmingly positive about its use (Dithan et al., 1996). The relatively high cost of the female condom compared to the male condom derives from several factors: polyurethane is more expensive than latex, more of it is used, and the manufacturing process is also expensive. Female condoms sell for between US$ 1 and US$ 3 in the USA and Europe, a price that is too high for the majority of potential users in developing countries. Expanding the range of choices is clearly important though, and research suggests that, if provided with a broader set of preventive options, women will try new and sometimes multiple methods, thereby achieving a higher proportion of protected sexual encounters (Elias & Coggins, 1996; Gollub, 1996). For this reason, a guaranteed purchase price of less than US$ 1 for public-sector agencies in developing countries has recently been negotiated between UNAIDS and the female condom's manufacturers.

Sexual communication

What remains to be ascertained is the impact of the female condom on sexual communication. Of particular importance is the extent to which the female condom may empower women in their negotiations with

men over the form and context within which sexual relations occur. Strong anecdotal evidence exists to suggest that the level of this empowerment may vary, since the impact of the female condom may depend on context (Williamson and Joanis, 1994). Learning more about the circumstances in which empowerment takes place is central to the success of future programmes and interventions involving the female condom as an HIV prevention technology.

Women's empowerment

Empowerment is a difficult concept to define and there has been much discussion as to its meaning in relation to sexual and reproductive health. For the purposes of this study, however, it is understood as implying an autonomy in sexual communication and decision making, based on an understanding of options for prevention, in the context of relevant resources for protection. Such a definition shares features with the approaches to empowerment recently offered by the 'Women's Empowerment Framework' (Longwe, n.d.) and by the Pan American Health Organization through its work on gender, health and development (Labonte, 1997).

Envisaging empowerment for women requires defining the power relations that need tackling as well as the means of changing them. In the context of sexual encounters, however, empowering women can mean a variety of things. These include not engaging in sexual activity with others, not engaging in sexual activity without informed consent, getting men to consent to safer sex practices, negotiating sexual practices which are pleasurable to women as well as to men, exploring sexuality independently, and developing an independent sexuality (Holland, Ramazanoglu, Scott et al., 1992). Whether and to what extent any of these changes are possible are questions that depend on the circumstances in which women find themselves. There is clear evidence to show that women are more able to put their intentions regarding safer sex into practice when they have some personal experience of empowerment (Holland, Ramazanoglu, Scott et al., 1992; Holland, Ramazanoglu, Sharpe et al., 1992). Empowerment therefore offers a starting point for practical strategies to transform sexual relationships between women and men. Possibilities of empowerment are, however, influenced by divisions and differences between women including those of class, ethnicity, culture and religion (Cain & Finch, 1981).

An important study in two contrasting communities in South Africa highlighted the contextual differences affecting women's empowerment in relation to the female condom (Preston-Whyte, 1995). Findings from this study suggest that women in one of these communities — Nhlungwane — were able to begin using the female condom because existing levels of political involvement made them confident enough to negotiate its use with sexual partners. This political involvement also encouraged other women in the community to follow their example. These women, who were aware of the constraints on their lives and the threats to their health as a result of economic dependence on men, saw the female condom as a potential means of managing risk. Their shared experiences thereby

became the resources on which to draw in communicating about sex with male partners and in negotiating the use of the female condom. Other studies also point to the importance of introducing the female condom in the context of group-based interventions in which women can gain support for change both from the intervention itself and from one another (see, for example, Shervington, 1993).

Concluding comments

Much attention has been given to issues of gender, power and women's sexuality in recent work in HIV prevention. This has highlighted the importance of taking account of women's own expertise and understandings. It is important that programmes enable women by offering support, information and opportunities to develop skills that would not otherwise be available. This way of working is part of a wider movement towards building *sexual citizenship* and a more expanded understanding of sexual and reproductive health (Working Group on Sexual Behaviour Research, 1995; Scott & Freeman, 1995). The studies described in this report reflect the growing desire to promote such ideals and to work with women and men in this way. They also derive from the belief that it is crucial to conduct research in ways relevant to a particular setting, and with the desire to ensure that findings are acted upon speedily, sensitively and appropriately (Gupta & Weiss, 1993).

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

In May 1993 the World Health Organization's former Global Programme on AIDS (WHO/GPA) published a general research protocol for studies of *Sexual negotiation, the empowerment of women and the female condom* (WHO, 1993). Both principal and site-specific research questions were included to enable intercountry comparisons to be made, and to ensure that data collected would be of value to those engaged in local work. Subsequent to the publication of the general research protocol, potential principal investigators from a range of countries were invited to prepare local research proposals. These proposals were reviewed by the former WHO/GPA Steering Committee on Social and Behavioural Research, and four studies — in Costa Rica, Indonesia, Mexico and Senegal — were recommended for funding.

Research questions

Studies supported under this initiative were expected to analyse: (i) prevailing gender relations, (ii) patterns and processes of sexual communication, and (iii) the possibility of empowering women in relation to sexual communication and negotiation through an intervention involving the female condom. The principal research questions to be addressed were as follows:

Gender relations

- Who exercises control in relation to sex and protection?
- Under what circumstances do established patterns of behaviour undergo change?
- How does the balance of power differ in the context of different types of sexual relationship?
- What is the effect of specific sociocultural contexts on gender relations?
- How do gender relations respond to increased awareness of HIV/AIDS and STDs?
- How do gender relations respond to the possibility of protection?
- If there are such responses, are they favourable to women?

Communication and negotiation

- How do men and women communicate about the terms under which sex occurs?
- How does this communication vary in different kinds of relationships?
- How does this communication vary in different sociocultural contexts?
- How do women negotiate the terms of sexual encounters specifically in relation to protective behaviour?
- How do participatory peer-led discussions strengthen women's inclination and abilities to negotiate protective behaviour?

Risk awareness and protective behaviour

- What is the general level of women's awareness about HIV/AIDS and STDs?
- To what extent are women aware of the protective value of condoms?
- To what extent are women able to influence the terms of any sexual interaction?

- To what extent are women able to introduce the female condom into a sexual encounter?
- How does risk awareness vary in different types of relationship?
- How does risk awareness vary across sociocultural contexts?
- What kinds of problems do men encounter in relation to awareness and protection?
- What do men understand to be the effects of the female condom on sexual practice and negotiation?
- How do men react to any changes that occur as a result of women's raised awareness?

Study design and samples

All four projects followed the design of the general research protocol outlined above, but some variations were included to meet particular local needs and contingencies. A two-stage design was used at each site. First, an assessment of prevailing gender relations, sexual communication and negotiation, and the nature of sexual and reproductive decision making was made. Conducted over a 2—3-month period, this assessment elicited the perspectives of women and men through key informant interviews, the analysis of existing documents and reports, and observation.

Secondly, an intervention took place designed to strengthen women's capacity in sexual communication and negotiation. Two groups of women were selected in each site: women not involved in sex work (group A), and women currently working as sex workers (group B). Given the preliminary nature of the enquiry, respondents were selected so as to be typical but not representative of important subgroups of women for whom the female condom might offer an important prevention option. The numbers of women recruited to each group and their principal social characteristics varied across sites (Table 2). For example, while women in group A in Costa Rica represented a relatively affluent section of the population, this same group in Indonesia was made up of the non-working wives of poorly paid workers. Similarly, group B in Costa Rica included only literate sex workers, while in Senegal this was not the case.

Given the exploratory nature of the studies, control groups were not established except in Mexico where local investigators were confident that women already knew about the female condom and its potential benefits.

The intervention consisted of two principal elements: (i) group activities to encourage women to discuss with one another prevailing gender relations, potential barriers to communication and ways of overcoming these; (ii) the distribution of female condoms along with guidance on their use. Group activities were designed so as to be culturally appropriate and in a format suitable to local expectations and needs.[1] In addition to the female condom, participants were provided with male condoms on request.

1 *The intervention in Mexico, for example, had the following components: a first meeting to explore participant's attitudes towards gender relations and sexual communication/negotiation in general; a second meeting to help participants identify personal assumptions about gender relations and sexual communication and negotiation; a third meeting to introduce the female condom and details about how it might be used. Further details of specific local interventions can be found in individual country reports.*

TABLE 2

Respondent characteristics

Country	Site characteristics	Initial assessment	Respondent numbers and characteristics (non-sex workers)	Respondent numbe and characteristics (sex workers)
Costa Rica	San José province	Preliminary forum involving local women's groups and potential study participants	Total = 32 Professionals (n=10), students (n=4), office workers (n=8) and housewives (n=10). Aged 20-40.	Total=32 Hotel workers n=16), bar workers (n=8), boarding house work ers (n=6), massage parlours (n=2). Aged 20-55.
Indonesia	Jakarta area	Formal and informal interviews with key informants; participant observation among truck drivers and sex workers	n=54 'Housewives'; for two thirds husbands worked in construction industry, for one third husbands were lorry drivers. Aged 20-41.	n=57 Sex workers recruited through 'rehabilitation centre'. Aged 17-32.
Mexico	Mexico DF	Key informant interviews, observation of places where young people meet, sex work contexts, analysis of secondary sources	n=60 (30 in experimental group, 30 in 'control') Mixed social background Aged 23-35	n=60 (30 in experimental group, 30 in 'control') Mixed social backgrounds Aged 23-35.
Senegal	Kaolack and Kolda	Group and individual interviews, observation with focus on form and context of sexual negotiation	n=25 Mixed social backgrounds Aged 16-40	n=20 10 'registered' and 10 non registered women selling/ exchanging sex Aged 16-40

Study sites

Costa Rica

Background — The research began with a preliminary forum to which women working in the fields of health and sexuality were invited. Thirty women attended this meeting to discuss the main objectives of the study and to identify themes to be explored during data collection. This initial consultation aimed to increase confidence and broaden ownership of the project and was considered highly successful in this respect. It also established criteria for the later selection of participants.

In stage one a questionnaire was administered to all the women in each of two groups. The questionnaire was designed to elicit data on sociodemographic characteristics, daily life, health and self care, sense of identity, relationship(s) with partner(s), sexuality, STD and HIV prevention, the female condom, and experience of sex work (group B only). In stage two of the study, women were offered psychosocial support through participation in confidence-building workshops with the following objectives:

- to prompt individual and group reflection on historical and current beliefs and attitudes towards women and in particular to women's right to control their own bodies and sexuality and to determine their own health needs;

- to strengthen participants' image of themselves in order to strengthen self respect and self care;

- to affirm women as active rather than passive in relation to their own health; and

- to ascertain to what extent sharing knowledge and information about STDs, HIV and AIDS might contribute to women's success in negotiating safer sex.

Research design — Two groups of 32 women participated in the study. All the women were resident in San José province, with the majority residing within the city of San José. The first group (group A) consisted of 10 professional women, 4 students, 8 office workers and 10 housewives. These women were aged between 20 and 40. Twenty-four of them were married, a further 3 were cohabiting, and all but 1 had partners who were in employment. Twenty-three of the 32 women in this group were mothers. All were considered to have what locally would be seen as a 'comfortable' standard of living.

A second group (group B) was made up of women working as sex workers in the following settings: 16 in hotels, 8 in bars, 6 in boarding houses, and 2 in massage parlours. Members of this group ranged in age from 20 to 55, with 27 members being aged between 20 and 35. Three women were cohabiting and 13 had a regular partner. Twenty-nine members of the group were mothers. Most of the women working as sex workers had financial responsibilities for children and/or other relatives.

Research process — In the first stage of the study, data were collected on participant characteristics, prevailing gender norms and patterns of sexual communication. In stage two, 16

women from each of the two groups were selected to take part in a seven-session workshop to explore the themes that had emerged in the first stage of the research. Selection took place on the basis of the women's degree of commitment and potential for group-based work. Each group met for seven two-hour sessions held weekly with an experienced facilitator. Discussions and activities focused on issues raised in stage one of the work, as well as those suggested by the investigators.

Indonesia

Background — This study included preliminary enquiry into patterns and processes of sexual negotiation followed by the evaluation of the effects of an intervention that aimed to empower women to negotiate safer sex through the introduction of the female condom. The key aims of the study were as follows:

- to obtain more information about gender relations and sexual communication/negotiation in two samples of women: sex workers and the partners of drivers and construction workers;
- to develop materials to provide women with information about HIV/AIDS and the need to negotiate safer sex *and* to introduce the female condom as an alternative protective strategy;
- to gain a better understanding of the effect of increased knowledge about HIV/AIDS on women's willingness to negotiate safer sex *and* on their willingness to try the female condom;
- to collect data from women on how they negotiated female condom use with partners;
- to collect data on women's experiences of using the female condom over a period of time;
- to gain an understanding of how the use of the female condom may influence women's willingness to negotiate safer sex in the future; and
- to gain an understanding of differences between the two groups of women in the study and their different reactions to the intervention programme.

Research design — Study participants were drawn from the Jakarta area because this was the province with the highest incidence of HIV/AIDS. Group A comprised the partners of drivers and construction workers. These men were seen as being likely to have multiple sexual partners. Group B was made up of sex workers. The main study was preceded by a preliminary investigation using formal and informal interviews with 14 key informants and participant observation conducted among truck drivers and sex workers.

The partners of drivers and construction workers were selected from two areas of the city — Pasar Rebo and Depok — where a large proportion of such workers lives. Women in the Pasar Rebo district were contacted through the wife of a truck driver already known to the research team. Participants in Depok were contacted through a driver who was known to the research team. In-depth entry-level interviews were conducted with

11 women in Pasar Rebo and 43 women in Depok. All were Moslems aged between 20 and 41 who reported having no sex outside marriage, but who were all sexually active within marriage. All were mothers, and the majority had less than six years of formal education. Around two thirds of the women's husbands worked in the construction industry, while the rest were drivers.

The sample of sex workers was contacted through a rehabilitation centre. A meeting was held at the centre attended by about 100 women, at which the aims of the project were explained. Entry level in-depth interviews were then conducted with 63 women, and 57 women participated in the study. Study participants were Moslems aged between 17 and 32, and the majority had no more than six years of formal education. For most, their first experience of sexual intercourse had taken place after marriage and before the age of 17. Over half the women had children who were economically dependent on them and taken care of by grandparents, often in their hometown or village. In the month before the interview, the frequency of sexual contacts varied from 4 to 90 and, in the majority of cases, individuals had had more than one partner in that month.

Research process — Within each session, participants were divided into groups of 10-15, each of which was led by a facilitator and cofacilitator. In the 'housewife' sample, one set of group sessions was held in Pasar Rebo and a further three in Depok, each of which had a facilitator and a cofacilitator. The group that met in Pasar Rebo had 11 participants who each attended every session. In the Depok groups, only one participant failed to attend all the sessions. Group sessions covered the following key areas: information about reproduction and contraception; STDs, HIV and AIDS; information and training in the use of the female condom; training in communication and negotiation relating to safer sex; and empowerment through sharing experience of female condom use. Female condoms continued to be distributed at the last two sessions and for one month after the sessions ended. Exit interviews were conducted with participants in the group sessions one month after the final session to enable individual reflection on their experiences of sexual negotiation and use of the female condom.

Mexico

Background — The study was undertaken in Mexico City through CONASIDA's AIDS Information Centres. It took the form of two parallel case studies of a group of 60 sex workers and a group of 60 women not involved in sex work. The study used qualitative methods and included in-depth interviews with individual women in each of the two groups; observations in places where young people meet; observations in massage parlours, bars and street sites where sex workers meet their clients; group discussions and focus groups. Additional background data were drawn from a questionnaire survey of sex workers attending an AIDS Information Centre to be tested for HIV and from data gathered in a focus group study conducted by the same research team in 1990.

Research design — The study had the following components:

- a rapid ethnographic study of the two groups as a result of which 30 women, aged between 23 and 35, were selected from each group to take part in the intervention;
- detailed interviews with each of the 60 participants;
- three intervention workshops at monthly intervals. Participants were provided with supplies of the female condom at the third workshop;
- focus group discussions three weeks after the distribution of female condoms at which further supplies were issued;
- detailed individual interviews two months after the second batch of condoms were distributed; and
- detailed interviews with the male partners of study participants.

Research process — Three intervention workshops were conducted as follows: workshop 1 aimed to investigate participants' attitudes towards gender relations and sexual negotiation; workshop 2 attempted to sensitize participants to their understandings of their own gender and their assumptions about gender relations; and workshop 3 offered information about STDs, introduced the female condom and showed participants how to use it. Interviews and focus group discussions took place after the distribution of female condoms to assess women's experiences using them, and the responses of male partners.

Senegal

Background — In Senegal, the study took place in Kaolack and Kolda, cities chosen to reflect the ethnic diversity of the country and the local incidence and prevalence of HIV and AIDS. Kaolack and Kolda are both poor cities experiencing rapid urbanization, but they have different ethnic profiles: Kaolack has a predominantly Wolof population whereas Kolda has a majority of Fulbe people. At the time of the study, Kaolack had the highest prevalence of HIV among sex workers in Senegal.

Research design — An interpretative qualitative approach was adopted. A rapid assessment first took place using group and individual interviews and observational techniques to collect data on the form and the context of sexual communication and negotiation. Ten research sites were subsequently identified within the two cities, and observations carried out in settings where nonconjugal encounters were likely to occur. These included hotels, bars, restaurants, dances and bus stations. Semi-structured interviews were then carried out with a total of 182 key informants. The target groups for these interviews included male heads of districts, leaders of women's associations or influential women in the area, 'housewives', women in paid work outside the home, registered and non-registered sex workers, and young people in youth associations. In Kaolack these individual interviews were followed by five group interviews that brought together women from different districts and ethnic groups, some of whom were involved either officially or unofficially in sex work. In Kolda 15 group discussions were held with sep-

arate groups for adult women, adult men and young people. Initially, it had been intended to select a subsample of study participants who would use the female condom, but such was the enthusiasm that all group members were given samples to use.

Research process — One person was selected from each group to act as liaison between the research team and the participants. With the help of this coordinator, five volunteers from each district/target community were selected to receive supplies of the female condom on a monthly basis. As a result of the different time scales followed by the study in the two areas, participants in Kolda were followed up over a six month period and those in Kaolack over three months. Fifteen out of the 50 participants dropped out during the follow up period. These were mainly sex workers who left the area.

Data analysis

In each of the individual studies, data were analysed thematically in relation to each of the research questions specified above. Thematic analysis commenced by examining existing records, documents, interview transcripts and fieldnotes to identify prevailing gender relations and their cultural and social determinants. The impact of gender inequality on processes of sexual communication was then explored with attention being focused on factors constraining and enabling communication between women and men. Perceptions of risk were identified before and after the intervention, followed by participants' experiences communicating about and negotiating the use of the female condom with their partners. Finally, the responses of women and men to the female condom were assessed along with their implications for prevention.

Given the exploratory nature of the studies described here, the different samples selected and the qualitative nature of the data collected, it is not appropriate to report the frequencies with which particular statements were made — indeed to do so would run counter to the established principles of qualitative enquiry. Instead, the focus is on the recurrent themes and issues that arose at each site, as well as those that existed across the different sites in the study. Unless otherwise stated, the views cited are those considered by the principal investigator concerned to be typical of the overall pattern of women's and/or men's responses at that site. Minority and idiosyncratic views are reported as such.

COMPARATIVE ANALYSIS

In this section, data from the four research sites are reviewed to identify what the four studies taken together reveal about the potential of the female condom to contribute to sexual communication and sexual negotiation in ways that are empowering for women. Data from the four individual studies are analysed in relation to five key themes: (i) prevailing gender roles and relations, (ii) patterns and processes of sexual communication, (iii) perceptions of risk, (iv) the negotiation of safer sex, and (v) the reactions of participants and their partners to the female condom and its impact on gender relations.

Prevailing gender roles and relations

In each of the four sites, women participating in the study pointed to important gender differences in self understandings, behaviours, roles and expectations. In Indonesia, for example, women study participants considered themselves inferior to men, and deferred to them either out of fear or in deference to dominant cultural values (Setiadi and Widyantoro, 1993). In Costa Rica and Mexico on the other hand, where forms of subordination may be more subtle, there was evidence that women are beginning to question traditional roles and have not so fully internalized a sense of inferiority. Although distinct roles for men and women were apparent in all four sites, the reasons given for these differences varied. In Indonesia, for example, the Islamic faith was seen as prescribing particular behaviours for men and women, whereas in Mexico and Costa Rica most women perceived gender roles as being shaped by a male-dominated cultural expectations.

Irrespective of the ways in which the women saw the reasons for differentiated roles, or indeed the merits of this differentiation, respondents in all sites saw women as more constrained, and perceived female roles as linked to expectations that limit sexual behaviour in a way that men's roles do not. One woman in Mexico commented that:

> *'In our society principally our sexual freedom is limited. A woman should be married in white, she shouldn't go out with a number of men because then she wouldn't be a nice girl. The more men who pass through your life the more devalued your image is.'*

Comments by women in all four sites suggested that female sexuality is more constrained and controlled than that of men. In all the settings where the studies took place, women were expected to have sexual relations exclusively with one man, while this was clearly not the expectation for men in these same cultural contexts.

Study participants commented that in addition to cultural expectations, the behaviour of women was also constrained by their economic dependence on men and the threat of withdrawal of this support. In Senegal and Indonesia, where polygamy may occur, the threat of a man taking another wife ensured greater female submission to male demands. In Indonesia, women expressed the view that men will be unfaithful or take another wife if a

woman gives poor service in the domestic and sexual arenas, and that compliance with his wishes is the best way of preventing this. One participant in Senegal highlighted women's economic dependence on men when she told researchers that she always complied with her husband's demands for sex ' ... or else he won't give me money to buy food'. While polygamy is illegal in Mexico, women here described how men commonly have more than one family, which limits the resources that can be offered to each woman and encourages greater compliance with male wishes.

In Mexico, Costa Rica and Senegal women were increasingly active in paid work outside the home. Women currently constitute a third of the economically active population in Costa Rica (National Centre for Women and Family Development, 1995) and a similar proportion work outside the home in Mexico (Garcia, 1993). Women participating in the study in Senegal reported that in spite of the traditional sexual division of labour whereby men are responsible for the production of cash crops, women are increasingly involved in work such as food production, crafts, clothing and domestic employment. However, men continue to hold land rights and have the power to authorize whether women can work outside the home.

Increased economic independence offers women a wider range of sexual and lifestyle choices. One woman in Mexico commented that:

> *'A clandestine relationship is more enjoyable, going out with a man who is committed [married or with a regular girlfriend or lover] is better than with someone who is there only for me, and who because of that begins to limit my freedom'.*

However, the new freedoms that women commented on were framed by traditional sex roles and the privileges afforded to male sexuality:

> *'I have lived alone for many years. In a way I have made myself, by myself. With many girlfriends who are professionals I have seen it; we are independent and they [men] see us in a competitive way... I feel many types of barriers; you are a professional and you live alone, they [men] have to be "careful" with you ...They still don't understand that it isn't a competition, but sharing'.*

Women in this kind of situation are often acutely aware of being caught up in a set of contradictions not of their making: 'As time goes by, your being single is dangerous for married women, and your girlfriends marginalize you', commented another woman from the non-sex worker sample in Mexico. Even with increased economic activity, women reported feelings of frustration in relation to their work and professional ambitions. One woman in Costa Rica not untypically commented that she 'wanted to be a journalist or a physical education teacher. Any profession where I could get out and about and meet people'.[1]

In spite of increasing opportunities for paid work, a clear division of labour was still reported at home. Those women who were economically active outside the home still took the greater share of responsibility for domestic

1 *Ambitions of this nature are influenced by social class as well as gender. The sample of women in Costa Rica included more women with formal education than in other sites.*

tasks and providing care for others. Indeed the role of caregiver was a valued role and a source of pride for most women interviewed. Moreover, women in Senegal who had become economically active outside of the home were not necessarily less economically dependent on men, and engagement with commerce could result in women facing additional sexual pressures. Respondents described how they were expected to exchange sexual services for commercial benefits such as access to transport, suitable accommodation and the smoothing out of customs formalities. The restaurants and bars run by women were often places where men expected to receive sexual services. Additionally, young women engaged in domestic work or selling food products were subject to sexual harassment from their employers and customers.

In Senegal, the registration of sex workers commenced in 1966. However, registered sex workers are still much less common than women offering sexual services on an informal but paid basis often out of economic necessity. As one such respondent explained:

> *'Before I got into this activity, I would serve as a maid in town, the maid's job could not yield a lot of money in relation to my needs, sexual activity can generate nightly the equivalent of a maid's monthly pay. At the beginning my parents were reluctant but now I am my family's main source of income. My father is now out of work and it's my mother, who sells vegetables and fish in front of our house, and myself, who provide for the household expenses'.*

Some women involved in sex work felt thwarted in their ambitions by traditional expectations of the female role. One sex worker in Costa Rica commented that she 'dreamed of making a family, having children, (and) having a man who loves me and looks after me'. Another woman from the same group said 'I dream of being a married lady, a housewife, (and) of finding a supportive man who loves me and my children'. The complex nature of gender relations is demonstrated here, in that women hope that men will play at least part of their prescribed gender role (that of provider), while it is also clear that economic dependence on men can lock women into a submissive role demanding their compliance with male wishes.

In two of the sites — Mexico and Costa Rica — some considerable questioning of traditional gender roles was apparent, and some women felt that they had broken out of traditional expectations, although often not without a struggle and not without paying a price. As a respondent in Mexico put it,

> *'We have rebelled. We consider ourselves less, we let them step on us, humiliate us, use us. In spite of my beliefs, I have let myself be stepped on, although I haven't wanted things to be that way. But we carry a cultural burden from centuries back which we are not going to get rid of in one generation, or because you have been to the university, or because you think a certain way; it's difficult.'*

Such women had clear ideas about their oppression. As one woman in Costa Rica described it,

> *'That is what women are for, to be screwed. At the middle level they see you as the secretary; in the home it's obvious. They see you as the secretary, as the one who screws, "I screwed her and now she is screwed"'.*

Findings from all four countries demonstrated how power is embedded in the gender relations characteristic of each site. Women in all four research sites were systematically socially disadvantaged *vis-à-vis* men, albeit to different degrees and with differing implications for their sexual relationships. Where women's levels of labour-market participation were increasing, such as in Costa Rica and Mexico, this did not necessarily lead to economic independence, mainly as a result of low wages. However, increased access to education and to the labour market appears to result in increased expectations about women's place in society and a greater likelihood that inequalities will be explained as cultural in origin and therefore potentially changeable. Thus, while respondents from Costa Rica and Mexico appear to be less satisfied with their lot, and in particular with their sexual relationships, this may be explained as much by a greater desire for independence as by more oppressive gender relations.

Women across all four sites continue to have the major responsibility for domestic work and child care, and even those who wished to be free of 'traditional' roles and definitions of women's work continued to gain a positive sense of self from being seen as caring. Where gender differences were most deeply riven into the culture and religion of a society, however, respondents were more likely to accept a definition of themselves as inferior to men and therefore to be less critical, or at least to have lower expectations about their lives in general and their relationships with male partners in particular.

Even where women had both a strong sense of their own autonomy and a strong desire for a different kind of relationship with men, as was the case for middle class study participants in Mexico, they were reliant not only on having a high degree of economic independence, but also on finding male partners who were committed to change. In order successfully to change gender relations, women need not only increased autonomy and economic independence but also a sense of empowerment and the experience of acting upon it. To be transformatory in the context of gender relations, empowerment has to be integrated both intellectually and experientially (Holland, Ramazanoglu, Scott et al., 1991).

Sexual communication

There were a number of parallels in the expectations and relationships underpinning sexual communication between men and women in each of the sites. The most important barrier to open communication about sex was the belief that talking about sex, and to some degree experiencing sexual desires and needs, is not appropriate for women, or certainly not for women who fear that questions will be raised about their character and morality.

In Indonesia, for example, women expressed the view that it was not appropriate for a woman to discuss sex or to express sexual desire openly to her husband. Non-sex workers participating in the study stated that such behaviour was 'improper', that they would be 'ashamed', and that they would be considered to be 'oversexed'. Women in the quite different cultural climate of Costa Rica expressed similar views, giving among

other the reasons for not talking with partners 'He may think I'm a bad girl' or 'Because it's vulgar, it is not polite. Women shouldn't even think about it' and 'I feel shy, inhibited'. In a range of contexts, therefore, cultural expectations about female sexuality and its expression inhibit the open discussion of sex. Women in Indonesia were, however, able to openly discuss contraception with their husbands and in general male partners were described as supportive of their wives' participation in family planning programmes, at least when female controlled methods were used.

Women in each country described how non-verbal communication was used to manage sexual interaction, especially that involving expressions of need. In Indonesia, women described ways in which they could express an interest in sex: 'If it's me who wants it, I pretend to show my thigh unintentionally, then he will know'. Women in Costa Rica, while saying that they made efforts to verbally communicate their desires, said this was difficult and found it easier to use actions rather than words. This illustrates the contradiction for women between having sexual needs met and maintaining a sense of being a 'good' woman. Showing too much sexual knowledge may cause questions to be asked about their propriety. 'As a woman, we are used to receiving, the man does everything. You are afraid they will label you, saying "Why do you know so much? Who have you been to bed with? How do you know?"' commented one respondent in Mexico.

Sexual relations in Senegal are underpinned by adherence to the Islamic faith and a set of prescriptive traditional social norms that differ significantly from those found in other sites. In Senegal, women's desire and need for sex is acknowledged and can be expressed through a variety of symbols including wearing special loincloths and pearl belts, and using incense and perfumes in the house. Although open verbal communication is not considered appropriate, the symbols used indicate clearly to men that their wives desire sex. As one woman put it,

> *'No husband can resist his wife if she desires to have sexual intercourse and uses the set of appropriate means of communication without feeling the need to ask for it by word of mouth, which would be an extremely shameless act'.*

Cultural norms and economic dependence underpin much of the sexual communication that takes place between men and women. In each site, women expressed feelings that demonstrated a lack of power to refuse undesired sexual activity with their husbands and partners, and in some cases the inappropriateness of refusing to have sex with a partner if he so wishes. 'A sane mind cannot imagine how a spouse could refuse to have sexual intercourse with her husband' commented one study participant in Senegal, while another said that 'Women must not wear pants in the night in order to make it easy for their husbands when [they] want to have sexual intercourse'.

In Indonesia, religious and cultural expectations may mean that women do not feel it is correct to refuse sex with their husbands: 'I don't feel right to refuse because I feel it's sinful. A woman is her husband's property, she is already bought', commented one

respondent. While women in the other sites did not appear to have internalized ideas about a man's right to sex, they often complied with men's desires in order to protect themselves from economic threat or, in some rarer cases, the threat of physical violence. Women in Mexico expressed a commonly held view that having sex, even when they did not want it, would 'avoid problems later'. Women in Indonesia also cited the fear that their partner would go elsewhere for sex as one reason for compliance.

A clear majority of women interviewed in each site reported being unable to communicate directly about sex in such a way as to influence the form and contexts in which it takes place, although some variations were found among some of the more highly educated and economically independent participants in Costa Rica and Mexico. However, adherence to strong cultural norms in Indonesia and Senegal assisted women in resisting sexual practices they did not want to comply with. Most women in Indonesia, for example, were able to resist oral sex because of cultural and religious norms that prohibit it. In Senegal, some traditional limitations to male influence over sex exist. For example, sexual intercourse should only take place at night and not on nights reserved for another wife. Intercourse is also prohibited during menstruation and, for some ethnic groups, during lactation. Outside of these limits though, force is considered an acceptable means of bringing about a wife's compliance. In all other sites, women expressed the fear that women who refuse to have sex with their husbands may be suspected of having extramarital sex. Interestingly, women in Senegal also described how the wives of men who did not fulfil their economic and other obligations might take a lover without social sanction. However, since men in Senegal control wealth and decision-making, and since polygamy is widespread, women still find themselves in competition with each other for limited resources, which constrains their power within sexual relationships with men.

Overall, a clear majority of respondents at all sites described relationships between men and women characterized by inequality, and expressed the view that they had neither the power to communicate openly about sex, nor in many instances the ability to resist sexual demands that they did not want to meet.

Women involved in sex work described their relationships with regular partners in terms similar to those of women who did not engage in sex work. Paid transactions differed substantially, however, and open communication between partners was much more common. The contractual nature of the encounter between a sex worker and client meant that women were not so concerned with promoting an image of themselves as lacking in knowledge and experience. Registered sex workers in Senegal said that they expected to control the price charged and the context in which sex occurs. These women usually take clients to their own or a friend's room, or to a hotel. Women who are not registered appeared to have less power to negotiate the form and context of the encounter. Clients generally choose where sex will occur and expect to pay a lower price for it. Unregistered women often do not wish to be seen as prostitutes and

avoid being defined as such by not fixing prices and hoping that men will show generosity after the event. Often no money changes hands, instead women bargain for services related to their other business dealings. However, even for sex workers in Senegal, symbolic and non-verbal communication is more usual than explicit verbal negotiation. Sex workers participating in the study in Costa Rica commented that while they were asked to offer a wide range of sexual services, the contractual nature of the relationship enabled some women to maintain boundaries, at least with some clients.

The key issue that emerges from all four studies was the extent to which gender expectations prevent women from being able to express their sexual needs and desires directly. Respondents expressed a range of reactions from lack of confidence to shame when speaking about sex, although in some cases, particularly among the Indonesian women, discussing contraception was more straightforward. Sex not infrequently failed to live up to expectations and while women had clear ideas about how they would like it to be, they were unable to ask for what they wanted. Reasons given ranged from powerful cultural prohibitions against women expressing sexual desire, to seeing any problems as their responsibility. Some women indicated that they would find it easier to communicate in more relaxed circumstances, but a clear picture emerges showing the contradiction between being sexually knowing and demanding, and being a 'good' woman. This tension leads to less direct attempts at communication which fall some way short of open discussion or negotiation. On the whole, sex workers find it easier to set the parameters of a sexual encounter that involves payment, although this is not true in their personal relationships. Where non-verbal skills are used, they range from complex and relatively formal erotic practices such as in Senegal, through subtle seduction techniques, to the more common pattern of attempts to determine the form of a sexual encounter by accepting or rejecting certain kinds of sexual advances.

In all four sites, women had little control over the frequency of sexual contact and gave in to sex they did not want in order to avoid problems, ensure economic benefits or to prevent their partner seeking gratification elsewhere. Women rarely referred to such pressures as rape or even coercion, but saw their responses as pragmatic reactions to the inevitable. Interestingly, the two countries with the clearest gender divisions appeared to have culturally acceptable strategies of resistance — in Indonesia, women felt they could invoke cultural and religious norms to resist certain sexual practices, whereas in Senegal it was expected that men's desires could only be met if women's sexual desires and the household's economic needs were first satisfied. While such resistance is produced in a context that is not of the women's choosing, and in some cases with strong limitations placed on what is acceptable, there appears to be a stronger basis for negotiation, if not for open communication, in these contexts than elsewhere. The culture of individuality that is more prevalent in Mexico and Costa Rica is compromised in the sexual arena by men's power and greater autonomy, and places women in a weaker negotiating position.

Perceptions of risk

Levels of knowledge about STDs and HIV/AIDS varied between the groups of women involved in the study. Women in Costa Rica, for example, were able to clearly identify STD and HIV transmission routes and methods of prevention, while women in Indonesia more often gave inaccurate answers to questions on these same topics. The findings in Indonesia are consistent with contemporary studies in that same country which indicate that most women, even those with a high level of education, lack knowledge about HIV and AIDS and risks relating to heterosexual transmission (see, for example, Setiadi and Widyantoro, 1993).

However, even where participants had high levels of knowledge about STDs and HIV they did not generally perceive themselves to be at risk of infection. For example, only four of the women in the group of non-sex workers in Costa Rica saw any need to protect themselves, while the others simply said they were monogamous. These women identified the stability of their relationships and trust in their partners as the reasons why protection was unnecessary. Although some of them felt that there might have been cause for concern in the past, they stated that their partner had now 'changed' and in some cases had been tested for HIV: 'I have confidence in him although it is possible that he could get infected'; 'He has changed and I'm more sure of his conduct although I know he could fall into temptation'.

For women, 'trusting to love' was seen as part of the role of a wife. There was an in-built assumption that being a 'good wife' and therefore a good woman rendered them invulnerable. The sense that they were protected by their status appeared to operate on two levels: at the cultural level where marriage is symbolic of a sacred state, and at the level of the relationship whereby responsibility for the self is invested in the partner.

Women selling sex had no such sense of being protected. Sex workers involved in the study in Costa Rica said that since they are aware that they are at risk of infection, they take measures to protect themselves by using condoms. However, even here there is a question of trust when dealing with regular and known clients. Sex workers in Mexico had a good understanding of HIV and its transmission, perceived themselves to be at risk and used a range of strategies to insist upon condom use. However, they did not us the same strategies in relationships with husbands and boyfriends, instead 'trusting to love' in the same way as other women in this study.

Sex workers in Indonesia did have some knowledge about STDs and HIV and said that under certain circumstances they would attempt to negotiate condom use. Although they were fairly knowledgeable about the symptoms of STDs, the main strategy they used to avoid infection was partner selection, refusing foreign clients or sailors who were perceived to present a greater risk. Respondents considered that they were protected from disease by taking antibiotics and traditional medicines on a regular basis, and by always washing and douching after intercourse. They also reported inspecting clients' genitals and said that they would ask for a condom to

be used or refuse sex if they thought a client had an infection. This group was also much less likely to suggest condom use with 'regular' clients or 'friends', especially if it was assumed that the client's only other sexual partner was his wife.

The research illustrates a range of different positions in relation to HIV/AIDS and STDs varying from a high level of knowledge and little or no sense of risk, through a high sense of risk with little knowledge or even misinformation, to no knowledge and no sense of risk. Only a minority of women in the four studies had a high level of knowledge and a sense of risk proportionate to their sexual behaviour, and only a small proportion of this group were able to 'negotiate' safer sex on this basis.

Negotiating safer sex

Not surprisingly given the findings already described, negotiation for safer sex in the four sites was limited. Three principal reasons accounted for this. First, women did not generally perceive themselves as at risk of STDs and HIV infection. Second, open communication about sex between men and women was limited. Third, women expressed the view that methods of prevention were both undesirable and unnecessary within the context of a committed and loving relationship.

Sex workers participating in this study were most able and most likely to negotiate safer sex because of the commercial nature of the sexual relationship and a heightened sense of their own vulnerability. Women in both Mexico and Costa Rica used a range of strategies to persuade clients to use condoms. The most common of these were to explain that it was good for both parties, telling the client to look for another woman if he did not want to use a condom, and explaining that they might get pregnant. If a client still resisted, about two thirds of the study participants said that they would continue to refuse to have sexual intercourse, while a third would go ahead but charge more, although the line between these two positions was not always clear.

Within the context of sex work, negotiation about safety and risk is often more open because the exchange is more explicit: women do not need to protect their reputation in the same way as women who are not engaged in sex work and are therefore more able to speak more freely. However, sex workers participating in the study in Indonesia said that they were often quite reluctant to speak to clients about potential health risks. Even when these women did suggest condom use, if the suggestion was rejected they tended to comply with the wishes of the client.

In Senegal, both men and women use symbolic gestures to indicate their willingness or availability for sex, so even for sex workers verbal negotiation about safer sex was limited. Male condoms were thought to be unerotic by study participants in Senegal. As one woman put it, 'With the men's contraceptive I do not feel anything and I do not want my partner to use it'. Here, as in perhaps other contexts, perceptions of sexual pleasure tended to override any concern for the protection of health.

Those most likely to negotiate for condom use were sex workers, partic-

ularly in Costa Rica, and women more generally in Mexico. The common theme that emerges from respondents not engaged in paid sexual activities is that of love, stability and assumed monogamy providing symbolic protection. As has been suggested elsewhere, 'trusting to love' is a particularly risky strategy to adopt (Scott & Freeman, 1995).

Responses to the female condom

The principal objective of this multisite study was to assess the impact of the female condom on sexual communication and 'negotiation' between women and men. It is important, however, to begin by saying something about the acceptability of the female condom in the particular contexts in which it was introduced, since an unfavourably received technology is likely to impact less strongly on sexual communication than will one which is more positively evaluated.

While the female condom was received favourably by the vast majority of participants at each site, initial concern was expressed when the female condom was first shown. Some women were worried by its unaesthetic appearance, whereas others were concerned about the potential reactions of partners. Among the concerns expressed were worries about anatomy and the potential for the condom to cause harm; the size of the condom and fit; worries about insertion; and anxieties about whether the female condom would heighten or lessen sexual pleasure. For those women who were not comfortable touching their own genitals, the female condom presented the greatest challenge.

Most of these concerns were allayed through the experience of using the female condom. In Mexico one women reported that her initial reservations had faded once she had begun to use it: 'I didn't think it would be so safe and so comfortable, it isn't even hard to put on, it doesn't do anything to you, and the pleasure is the same'. In all countries, women claimed that curiosity and the novelty of the condom had encouraged men to try it out. In Senegal one woman observed that '... Men like discovering tricks, having experiences and new things as is the case with the women's condom'.

Most respondents and their male partners drew favourable comparisons between the female condom and its male counterpart. In Senegal a women working as a sex worker said:

> *'A lot of clients, once they have tried it ask me to use women's condom because they do not like the men's condom which in their opinion decreases vitality and may even make them impotent.'*

Sex workers gave particularly favourable accounts of the female condom. Listed benefits included increased lubrication making sex work more comfortable and encouraging clients to ejaculate more quickly; preferable to the use of sponges when menstruating; and easier to persuade clients to use. As another sex worker in Senegal reported:

> *'I prefer the women's condom. Before with the men's condom I suffered during sexual intercourse. I have a narrow vagina, I felt so bad and I had things like tears especially ... when the man's drunk and he takes time to ejaculate. Now because of the lubrication of the female condom my partners ejaculate*

rapidly, which tires me less. And instead of pain I feel smoothness.'

Introducing the female condom in the context of a group setting had a clear impact on sexual communication between men and women. Women in all sites, but most especially those in Mexico and Costa Rica, expressed feelings of empowerment triggered by having a form of protection over which they had control. 'I feel better knowing I have it, that I'm armed with it, that I have the power'; 'It is like having control, power. Apart from that it feels good' observed two women participating in the study in Costa Rica. Another woman in Mexico commented enthusiastically that:

'It feels really great ... You feel really free. Oh, it's the best invention since birth control! I like it better than the male condom because even when you are menstruating you can use it, you can control the situation, you are taking care of yourself, you don't depend on another person ... You can change positions without any problem and begin again'.

Women in all study sites commented on how important it had been to learn about the female condom in groups and in a generally supportive environment.[2] This helped them talk about their experiences and value themselves. In Costa Rica one woman said, '... it meant a lot because I have learned to value myself more as a person, as a woman'. Another woman at this same site commented 'It has been important for me to be able to share, to be able to study my experiences, to see that I wasn't alone in the things that I have gone through (and) that those experiences were not exclusive to me.'

Communication skills were crucial in gaining male agreement for use. The wives of drivers and construction workers in Indonesia were particularly successful in persuading husbands to use the female condom. Women's ability and willingness, developed through group sessions, to assert the desire to use protection in the first place was key in sustaining the use of the new device. It is important to note, however, that although the women in Indonesia were reticent to raise any issues about sexuality with their husbands that might cast doubts over their being 'good women', issues of family planning had been discussed previously, and male support for this had already been forthcoming.

In Senegal, the female condom was perceived by respondents as lying firmly within the female domain. As such, it did not challenge male power or virility, which was a positive factor in encouraging men to accept its use. However, some men did express concern that the female condom would facilitate greater freedom for women, including increased opportunities to engage in sex outside of marriage.

In this same country, women were often able to use powers of persuasion even when male partners were reluctant to use the female condom:

'Some time after the start of the follow-up my husband began to grow weary of the women's condom and no longer wanted to have sexual intercourse with

2 *This is not to say that in the absence of group activities the female condom does not offer a useful female controlled prevention technology. It is to suggest that when introduced alongside such activity, its capacity to offer women a way of reducing sexual risk is enhanced.*

it. I appealed to his feelings and gently told him that I was much attached to it because it is an excellent way of contraception which does not present any inconvenience and as we had agreed to space out my pregnancies, he had to accept it. I made tasty dishes for him and did everything to coax him'.

Using all their resources and utilizing local cultural norms, women in Senegal were sometimes able to work together with their husband's other wives to persuade men to continue to use the female condom. One respondent told the researcher:

'When you came to tell us about the female condom my co-wife was away on a trip. When she came back she heard about it in conversations among women and informed me of her fear of STDs and AIDS as well as her wish to participate in the follow-up group. Then I asked the researcher on the project whether it was possible and it was. Thus my co-wife and I were accomplices and my husband could not prevent both of us from using the female condom'.

Women in Senegal also reported that the female condom had been incorporated into sexual play between husband and wife, often becoming in itself a mechanism for increased sexual pleasure: 'When my husband wanted to have sexual intercourse with me ... he went to look for the women's condom himself, tore the sachet and placed it in my vagina with gestures which pleased me as much as they did him'. The impact of the female condom on sex play was extremely important in Senegal where the major concerns expressed by the women at the beginning of the study were about whether or not the female condom would enhance sexual pleasure.

Women also reported a greater degree of male involvement in using the female condom than might have been expected given findings about poor sexual communication. In each site, a small number of women who had some difficulties with insertion asked for and were offered help by partners. This involvement may be very important in encouraging the beginning of a sexual dialogue between men and women, and also helped men feel that they still had influence over the form of protection used: 'I told my husband that I had difficulty gripping the internal ring and placing it because of the lubrication. As he could help me he was then very proud of succeeding in introducing it into me correctly' reported one respondent in Senegal.

The promotion of the female condom within the context of a respected research programme also enabled women to encourage men to continue use. In addition, in Senegal women were able to use the dual legitimization of community support, by arguing that most local women had taken up the female condom, to influence the decision of their partners.

Sex workers in all the sites reacted more positively to, and reported that their clients also favoured, the female condom over the male condom. The former put more control into women's domain, and some sex workers did not even tell their clients prior to sex that they were using the female condom. In Mexico, sex workers largely imposed the condom on clients rather than negotiating use, although men could be persuaded because of a sense of adventure and novelty: 'You can make them feel ignorant for not knowing it existed and take advan-

tage of the novelty of it and the desire of the client to be adventurous and experiment'. In Indonesia, sex workers reported feeling more confident about persuading clients to use some form of protection after the intervention, and that the female condom provided new bargaining power with clients who refused to use the male condom.

CHAPTER 5

CONCLUSIONS

Findings from this international study of gender relations, sexual negotiation and the female condom suggest that women are constrained in their sexual behaviour and choices by two major factors: economic dependence on men which makes it more likely that women will comply with male wishes, and gender stereotypes which inform expectations of female and male sexual behaviour and create problems for sexual communication.

The choices women make about when, how, where and with whom they have sex are more constrained than those of men. Even with husbands and in the contexts of long-term relationships, women express reticence in discussing sexual matters with partners: either because they feel this is inappropriate and 'unfeminine', or because of fears that such discussion will be ill received by partners. Although women sex workers find that the contractual nature of relationships with clients facilitates a more open discussion of sexual matters, some find it difficult to openly communicate and negotiate with clients.

The evidence from this study suggests that the female condom will be most successful in enhancing sexual communication and women's empowerment in the following contexts:

- with sex workers who already have some experience of negotiating safer sex with clients, such as those women participating in the research in Mexico and Costa Rica;
- with couples where men are already supportive of family planning, such as those in Indonesia;
- where a sense of community involvement is thought important and where, through this, men can be reassured that acceptance is high among their peers, as in Senegal;
- where the male condom is unpopular, thus rendering the female condom a preferable alternative; and
- where the female condom can be eroticized and introduced into sex play, such as in Senegal.

The female condom may have less impact on sexual communication and negotiation where there is little or no tradition of talking about sex, where women believe themselves to be at low risk of infection, and where partners 'trust in love' as a means of protection against STDs and/or HIV.

The women in this multi-site study reported that men, be they regular partners or clients, were with only rare exceptions unenthusiastic, if not hostile, towards the use of male condoms. Male condoms were considered to decrease pleasure, pinch, rub and cause men to lose their erections.

Although some women expressed concern about the decrease in sensitivity said to be associated with the male condom, the majority of the women not favouring the use of the male condom in these studies focused on men's problems with condoms and

the difficulties of overcoming these. Findings from this study suggest that, when introduced in a particular context, and when accompanied by group work and training of the kind described earlier, the female condom does not have the same negative associations that inhibit the use of the male condom.

Interestingly, some of the women who were most successful in introducing the female condom into their sexual relationships were operating in contexts where there was least likelihood of open verbal communication and negotiation. They include women sex workers who simply imposed the female condom on their clients and found that the latter either did not notice it, or were happy not to be asked to use male condoms. The other context in which the female condom seems to have been relatively easier to integrate was amongst the non-sex worker sample in Senegal. Here, the important factor was the legitimacy of women's engagement in erotic play in pursuit of their husbands' pleasure, which meant that the female condom could be eroticized and read as an indication of the woman's willingness to have sex.

For the majority of the sex workers participating in these studies, protected sex with a regular partner was not considered appropriate. This distinction was often extended to regular clients who counted as friends. This is an understandable distinction and is probably one that, while potentially risky, is emotionally necessary.

The need for trust in intimate relationships (Giddens, 1990 and 1991), and the contradictions that this raises in relation to the practice of safer sex (Mane & Aggleton, 1996; Scott and Freeman, 1995), were salient to all the women taking part in this study. It is difficult for women to accept that they may be at greatest risk from those closest to them, especially if this entails openly acknowledging matters it is sometimes more convenient to ignore. Using the female condom other than for contraceptive purposes is likely to entail acknowledging that a partner is not trustworthy. This is particularly difficult in situations where monogamy is prized and individual failure is stressed in the context of a partner's infidelity. It may then be easier to promote female condom use in social contexts where it is openly acknowledged that men may have multiple partners, but where they resist taking responsibility for this in relation to their own sexual practices and condom use.

In all sites, study participants were willing recruits with relatively high levels of motivation to learn more about sex, sexuality, contraception and health matters or simply to participate in some special set of activities focused on their needs. It is clear from the data that the majority of women found that the process enhanced their confidence and sense of themselves as competent social and sexual actors with rights to some autonomy with regard to their bodies and sexuality. It was also clear that where women were able successfully to introduce the female condom into their sexual relations, this in turn increased their sense of empowerment. The success of this particular research/intervention design means that the likelihood of successfully introducing the female condom into these, or any other, settings or situations without group work, training and other similar develop-

mental work, may not enjoy the same level of success. It is clear that the most successful interventions to prevent further HIV transmission are those that respect the needs of the local community and are gender aware (Mane, Aggleton, Dowsett et al., 1996).

For those women who have little or no experience touching their own genitals, the female condom can present some problems with insertion, although it these difficulties appear to decrease with time, may be alleviated with some assistance from willing partners, and may relate more to anxieties about the body than to female condom use itself.

Somewhat paradoxically this study of *Gender relations, sexual negotiation and the female condom* suggests that the female condom can be introduced with success in certain contexts and circumstances, and without major disruption to the present balance of power in heterosexual sexual relationships. However, since the female condom may be used as a tool in the development of women's sexual confidence and autonomy, this may open up the possibility of greater equality in sexual relations, between men and women. There are indications that the introduction of the female condom can increase women's sense of self-efficacy and self worth in ways that have effects on their lives beyond the immediate issue of condom use. This possibility for seeing both the intervention and the condom as having some transformatory value is illustrated in the words of one Mexican woman:

> *'After the workshops, it's like you find more words to talk to them [men] differently, and they feel good with the condom. That was when the change happened and I decided that I can have a voice and a vote, and it is not only his decision. I have a right to feel loved and desired'.*

The female condom also offers women a method with which to protect themselves where none existed previously. This increases options for women, especially those who want to protect themselves against HIV and other STDs as well as pregnancy, but who face resistance from men who do not want to use male condoms. The female condom also offers an alternative to the male condom which is more dependent on male compliance and not under women's control. Follow up work needs to be undertaken, however, to ascertain the extent to which the use of the female condom can be sustained over time without the need for wider social and attitudinal change.

Recommendations

The following more specific recommendations derive from the findings of this multi-site study:

- The female condom provides women with an extended choice of means of protection. A number of recent studies have demonstrated that extending choice and enhancing women's options increases the number of protected sex encounters (Elias & Coggins, 1996; Gollub, 1996). Increasing the availability of the female condom therefore has an important role to play in reducing sexual risk.

- There is clear evidence that the female condom is used within, and

integrated into, the context of broader, local social norms about sexuality and reproduction. This has implications for how the female condom is best presented to women and their partners, and emphasis the importance of interventions that are context aware and context specific.

- Introducing the female condom into a given community is unlikely to be sufficient to promote its extensive use or encourage any significant change in sexual communication between men and women. The female condom needs to be introduced within a context of appropriate training and group work which helps women to build their confidence and skills in sexual communication.

- The female condom, when introduced in the context of a planned intervention, can impact on sexual communication and add a new dimension to it. There appears to be an inverse relationship between the level of open, verbal sexual communication before the intervention and the impact of the female condom on sexual communication afterwards.

- It may be particularly helpful to introduce the female condom into environments where there is some history of male condom use, but where this use is characterized by inconsistency and unpopularity. The female condom is well received when the male condom is an unpopular alternative.

- Interestingly, and somewhat paradoxically, the introduction of the female condom in a planned intervention may have the dual effect of helping women to feel empowered, while not making men feel threatened. This provides fruitful grounds for further exploration of issues around negotiation and the power relations between men and women.

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Notes:

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together seven UN agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its seven cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners – governmental and NGO, business, scientific and lay – to share knowledge, skills and best practice across boundaries.

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Joint United Nations Programme on HIV/AIDS

UNAIDS

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